Outcome and Assessment Information Set (OASIS) for Home Health Care

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INTRODUCTION:

Senator Grassley, Committee Members, and fellow panelists:

I want to thank you for the opportunity to address you with comments on OASIS this afternoon.

I come from a small community hospital based home care agency in central Iowa. But in essence, I represent all Iowa home care agencies and many across this great country. In preparing to come today, I queried my peers in Iowa and across the nation and found that their views are similar to mine. Therefore, I feel that I can adequately represent an agency perspective on the issue at hand.

It is imperative that the Senate Special Committee on Aging has a clear understanding of the effect of the OASIS data collection on the elderly in America. As you are probably aware, Iowa ranks number two in the nation for the number of people over the age of 65 per capita. Further, Iowa has the distinction of ranking number one for the number of elderly over the age of 85 per capita. Nestled in the heart of Iowa are two counties side by side - Calhoun and Greene counties - who have the distinction of ranking number one and two, respectively, in Iowa for the number of elderly over the age of 85 per capita. Therefore, it is fair to say that our agency takes care of the oldest of the elderly in the nation. In addition to the challenges of serving a large elderly population, fragmented family systems and the number of elderly living in poverty challenge us. I will attempt to help you understand the effects of the OASIS data collection system on your elderly constituents.

Our agency, and the nation's home care industry, has long supported the use of a uniform data set for collecting data, and measuring and ultimately improving patient outcomes in home care. Further, we are supportive of the Health Care Financing Administration's (HCFA's) efforts to develop a case-mix system for a home health prospective payment system (PPS). While many benefits may accrue from OASIS, we continue to believe that several actions must be taken before home care providers can adequately undertake OASIS data collection and assessment requirements. We are committed to collaboratively working through the bugs as opposed to eliminating a system that has already required a considerable amount of valuable resources to implement.

I will present information as statements of problems, followed by recommendations. This presentation will address nine (9) issues:

Effect of the OASIS on the Elderly

OASIS Data Collection for Medicare Patients Only

Privacy Rights of Patients Must Be Protected

Modification of OASIS Timeframes

Burdens on Agencies

PPS System that Truly Reflects Home Care Resource Consumption

Reimbursement of the Cost of OASIS Implementation

Adjustment of IPS if PPS Implementation is Delayed

HCFA's Responsibilities to Providers

Effect of OASIS on the Elderly Patient

It appears that OASIS is more applicable to patients who have acute illnesses with rapid recovery. Most patients over the age of 85 do not make a full recovery after acute illnesses. Their advanced age, coupled with numerous health problems, lack of independence, lack of sophisticated service delivery in rural areas, and, often lack of a spouse or relative as a willing and able caregiver, lead to the provision of long term home care services. It is not uncommon to see little change in an elderly patient's condition, as reflected in OASIS, over the course of a year. Many of our elderly clients are maintained in their homes with a conservative number of visits, such as a skilled nursing visit every 1-2 months and aide visits 2-3 times a week (with the required, non-reimbursable every-two-week visit to supervise the aide). The current OASIS instructions require data collection every two months. That means that every visit or every other visit by the nurse requires extensive questioning of the patient and documentation by the nurse.

Patients become impatient, tired and/or annoyed with the OASIS data collection process. The home health admission process is already exhausting to the client. The required components are lengthy: completion of admission assessment including the OASIS data questions, complete physical assessment, explanation of rights, explanation of advance directives, explanations of agency policies and on-call system, determination of an emergency plan, determination of payment of services, and signing of agency forms for admission and release of information. Some clients are unable to complete the assessment process in one visit, necessitating repeated visits to the home. Our clients are worn out. They are frail and fragile. Our staff have encountered hostile caregivers, because we have "tired out Mom" or "delayed them from being able to get back to work timely" or "made dad decide he didn't want services".

When clients reach 80 years and beyond, they require more physical assistance from the home care aides and closer monitoring by the nurse. Frequently, they require assistance with setting up medications, grocery shopping, laundry, and environmental cleaning. Many of these services are not paid by Medicare because they do not constitute skilled services or personal care services. We provide these services through state grants, funding from the Iowa Department of Elder Affairs, and county taxes. The burden of OASIS on these non-Medicare funded services has the effect of reducing the number of individuals that can be served. We are using precious resources to collect data rather than care for our elderly.

RECOMMENDATIONS:

HCFA should modify OASIS requirements to reflect that completion of OASIS will only be required at admission and discharge to home health services, with an annual update of the OASIS for chronic care clients needing care longer than one year.

HCFA should modify the OASIS data collection system requirements as addressed in #2, #4 & #5 below.

OASIS Data Collection for Medicare & Medicaid Patients Only

HCFA has required OASIS data collection and reporting on all adult, non-maternity patients served by the Medicare or Medicaid certified agency. This includes private insurance patients, those paid by state and local governments, those paid by grants, and those paying for care out of their own pockets, regardless of payer or patient health status. It also includes terminally ill clients who have not elected to opt for the Medicare hospice benefit.

HCFA also requires OASIS data collection for clients who receive homemaker/home helper services, such as home cleaning and grocery shopping, not funded by Medicare or Medicaid. These services help elderly patients stay in their homes. To add in extra visits, time, and cost to these programs will limit agencies' ability to provide cost effective services; the net effect will be shrinkage of services due to an increase in administrative costs.

In addition, even though HCFA has specified that only twenty (20) specific OASIS data elements will be used for the case-mix system, the regulation requires that all seventy-nine (79) OASIS data elements be collected at least on admission and discharge for each patient. Many of the OASIS data items won't be used for prospective payment and are of questionable value for quality assurance.

Some private pay and insurance pay patients are refusing to answer OASIS questions, resulting in the agency notifying the client that they cannot provide services to them in order to remain in compliance with HCFA and state surveying agencies. Further, there is mistrust among the providers that HCFA will use the data from private-pay and insurance paid cases, distorting the case-mix adjusters that are critical to PPS. Since PPS is a Medicare reimbursement system, only Medicare patients should be involved in OASIS data collection.

RECOMMENDATIONS:

HCFA should modify the regulation to require OASIS data collection only on Medicare clients receiving intermittent skilled services that are funded by Medicare.

HCFA should modify the regulation to allow flexibility at the state level to administer Medicaid requirements for data collection to ensure requirements best-fit state designed programs.

HCFA should modify the regulation to clearly communicate the elimination of the OASIS requirement on private-pay, Medicare HMO, and private insurance clients; on care funded by state and local governments or other grants; and on private duty and homemaker/home helper services.

HCFA should mandate only the OASIS data collection items that are necessary for determination of a PPS system. HCFA should only consider implementing a quality agenda after successfully demonstrating their ability to manage the volume of data items necessary to deliver on a timely PPS system implementation.

No patient should be denied access to services based solely on his/her refusal to grant agency permission to transmit OASIS data to HCFA.

The PPS system must be based upon OASIS data for Medicare-funded care and information on the total number of Medicare reimbursed and non-reimbursed visits needed to maintain the client in their home. HCFA needs to have a full understanding of the total cost of care needed to care for a client to make

policy determinations about a long-term home care benefit or cost-adjustments for patients whose care makes them an outlier in the current system.

HCFA should modify the regulation to eliminate the OASIS requirement for terminally ill Medicare and Medicaid beneficiaries who are served in traditional home care (not enrolled in Medicare certified *hospice* care).

Privacy Rights of Clients Must Be Protected

Many of the OASIS questions address the patient's health status and, as such, are protected as confidential medical information by the Federal Privacy Act of 1974. Some of the questions deal with especially sensitive areas such as whether the patient is able to afford food, reports feelings of hopelessness, or has attempted suicide. OASIS in its current form links personal information with identifying information, including patient name and social security numbers. The collection of OASIS patient information, if used inappropriately, could cause great harm to patients.

Identifying information, no matter how well encrypted, has no place in a national database. HCFA has not published a System of Records to protect this data as required by federal law.

RECOMMENDATIONS:

HCFA should modify OASIS requirements to allow for transmission of admission and discharge OASIS data to HCFA upon discharge of the patient. This would eliminate the need for patient identifiers attached to the data to track clients over time.

Assignment of a case number system, or agency assigned identifiers, for data submission could be incorporated to protect patient privacy without compromising outcome analysis activities.

No patient should be refused services on the basis of an unwillingness to consent to the transmission of confidential information.

Modification of OASIS Timeframes

The initial assessment is required within 48 hours of the referral, or within 48 hours of when the patient returns home, or on the physician-ordered start of care date. Agencies are required to implement a tracking system to monitor that the timeframes are met. It is not uncommon to receive referrals on patients when adult children are home for visits, with the request that services begin the following week after the visitor leaves. The agency should be able to schedule visits to meet the patient's needs.

HCFA regulation requires that the updated comprehensive assessment occur "as frequently as the patient's condition warrants due to major decline or improvement in the patient's health status.". The final rules do not define what constitutes a major decline or improvement in the patient's health status. This leaves a large gap of potential judgement on the part of Medicare State Surveyors to determine if the agency is in compliance on this requirement.

There is confusion about the need to obtain a physician's order for the visit to update the OASIS.

There are times when the physician's orders do not coincide with the timeframes for OASIS assessments that must be updated by a home visit to interview the client. Section 204.2 E3 of the Medicare manual (HIM-11) reads, "any increase in the frequency of services or addition of new services must be

authorized by the physician." An agency must obtain an order to increase visits to the patient. However, requiring the agency to obtain an order for these visits will require additional calls to the physician; this is likely to be undesirable for the supervising physician and a paperwork burden for the agency.

HCFA regulation requires that reassessments for OASIS occur every two calendar months from the start of care date and that the assessments must occur "no earlier than five (5) days before, and no later than one (1) day before the calendar day on which the certification period ends." This conflicts with the historical and traditional method for writing certification periods, as certification periods may be up to sixty-two (62) days, but may be shorter. It is possible for the certification periods to change over time, to not coincide with an every two calendar month date following the start of care date. Additionally, recertifications sometimes require additional non-reimbursed visits when an ordered and billable service does not coincide with the restrictive 5 days window requirement between days 57 and 62 since the start of care. Non-Medicare clients, with med box set-ups, insulin syringe fills, injections, etc., makes timing impossible. Elderly clients, some with declining cognitive status, don't understand the need to change the visit schedule to accommodate OASIS requirements. Customer service, as a quality initiative, implores agencies to allow the client to have input into the schedule of visits. Victimization of clients and agency staff to meet provider information collection systems should not occur.

RECOMMENDATIONS:

HCFA should modify the final rule to remove the requirement to collect reassessment OASIS data. Admission and discharge data should be sufficient to determine the case mix adjuster for PPS.

If elimination of reassessments is not agreed upon, HCFA should modify the final rule to:

- remove the ambiguous and undefined language relating to administration of the comprehensive assessment for "major decline or improvement in the patient' health status."
- clearly communicate that physician orders for the visits made to update assessments are not required.
- base update assessments upon the patient's certification period rather than every two months based upon the start of care date.
- allow update assessments to occur within a 2 week period prior to the recertification date to allow patients more control in determining their visit schedule, and agency staff more flexibility in meeting the requirements.

Burdens on Agencies

The complex and costly requirement to implement OASIS is being imposed upon home health agencies at the same time that we are being forced to drastically reduce our costs under the stringent limits of the Interim Payment System. The data requirements far exceed what is necessary to monitor quality and implement prospective payment. Further, there has been a lack of consistent guidance and answers about the new requirements, and there are continuing costs incurred each time HCFA makes more changes to the tool.

Our agency has spent approximately 100 nursing hours developing new assessment tools to incorporate OASIS questions into a complete assessment that would also meet Medicare Conditions of Participation and Joint Commission (JCAHO) standards. Our assessment tool increased from 3 pages to 26 pages in length. We have spent over 125 hours in staff education and training.

Our admission process has increased an average 1 hour for patient interview and data entry; it is now up

to a 6 hour process including the home visit, travel, and documentation. The reassessments have increased visits by an average of 30 minutes each. Transfer assessments are relatively easy and only require 5-10 minutes. Discharge assessments take an average of 15 minutes.

During March and April, our nursing staff saw a dramatic increase in the size of the patient's records. When a patient was admitted to the hospital and came home again, extra nurse time was required to complete discharge OASIS items, and a readmission OASIS, thus adding thirteen (13) pages to the client's record within a week! This certainly does not meet our definition of paperwork reduction!

The need to visit patients for reassessments - when no visit has been ordered by the physician - to update the assessment has led to unreimbursable visits. During March and April, our agency staff made twenty-three (23) non-billable visits to collect OASIS data. The rigid timeframes imposed in reassessments and the requirement that a visit is necessary for reassessment cause an administrative burden on agencies. The nurse should be able to assimilate the data she knows about the client, augment it with a telephone call, and complete a reassessment.

We have a philosophy of teaching our patients to be self-sufficient and making a conservative number of visits. We have been "rewarded", for this prudent behavior, with Interim Payment System (IPS) per beneficiary limits of $900 - $2500 per year, while being required to implement costly data collection systems such as OASIS and the 15-minute billing increment reporting. An across the board IPS rate based on national norms, rather than penalizing the cost-effective agencies is needed. Why should a new agency just down the road be allowed a per beneficiary limit the amount of ours is just because they are new?

Finally, there is a morale issue brewing in home care. We begin each staff meeting with, "As of today, this is the reality we know.", and we close with, "Until we hear differently." Our staff is among the best. They have tried very hard to meet the intent of the requirements placed upon our agency. They face ethical dilemmas on a daily basis between what they believe is quality care and what we can afford to provide and still stay in business.

Our clients don't understand the need for OASIS or what IPS is all about. In fact, they are being told by Medicare that there is no change in payment for home care, and that it is their right to receive whatever care they need under their Medicare benefit from the accepting agency.

RECOMMENDATIONS:

HCFA must be required to operate under the *Paperwork Reduction Act*.

HCFA should modify OASIS requirements to eliminate the need for reassessment and transfer OASIS data collection.

If reassessments remain as a requirement, HCFA should modify the OASIS requirements to:

- allow for reassessment to be based upon the professional nurse or therapist's knowledge about the client without requiring a home visit, **or**
- allow the reassessment to occur within 2 calendar weeks prior to the recertification date.

PPS System that Truly Reflects Home Care Resource Consumption

Perhaps the greatest fear among my colleagues is that HCFA will enact a prospective payment system

based solely upon a medical diagnosis. Senators, this would be a grave mistake. Home health care is primarily based upon nursing care. Nursing care is the care of human responses to diseases and conditions that are classified by medical diagnoses and further quantified into ICD-9 or DRG codes. Nursing care *is not* determined by medical diagnosis alone! Particularly in home care, the care plan is determined by the patient's age, ability to complete basic activities of daily living (ADLs), and the ability to learn self-care processes that are related to medical diagnoses. The care plan can also impacted in rural areas with limited community services (i.e. meals on wheels, local grocery stores, transportation services, etc.), as home care agency staff must make arrangements for services that their urban counterparts take for granted.

Lack of an able/willing caregiver continues to be a critical variable *dramatically* influencing the amount of services an agency needs to provide. Remember, some of our clients are 90-110 years old. That means that their children are aged 60-80 years old!! The caregiver is essential to safety issues, formation of an emergency plan, compliance with medications, transportation to medical appointments, etc. when the client is unable to manage these activities independently. When clients don't have someone available to assist them with ADLs, the agency may be the sole support system for the client. For example, if the client is unable to put on elastic support hose, bathe, or manage medications, the agency's care plan looks very different when there is not a capable support person or caregiver present to take on these duties. This translates into more visits by the agency.

There may be a caregiver present, but he/she may not be able or willing to provide the care that is needed by the client. For example, OASIS doesn't adequately take into account that the location of a wound might affect whether a patient is able to care for the wound independently. Not all caregivers are willing to take on extensive wound care, catheterization, inhalation treatments, IV administration, or other nursing skills. Even if the caregiver is willing to provide wound care, an ulcer on the buttocks, perineum, breast, or other private area of the body affects whether the patient wishes for a family member or friend to help them.

Nationwide, agencies agree that the caregiver variable is absolutely essential in predicting home care resource utilization. Iowa agencies know that the presence of an able and willing caregiver is perhaps the biggest variable in caring for the oldest of our elderly and frail clients. However, we are hearing rumors that HCFA believes that to be a source of fraud and abuse in home care reimbursement. Senators, there must be other ways of handling fraud and abuse through claims review processes rather than to blindly ignore the honest Iowa home care professionals' knowledge about what works for the nation's most elderly clients.

The data collection does not look at the number of visits required by various disciplines or the amount of case management/coordination of care required. Even if privacy concerns are ignored and HCFA has the ability to compare the OASIS data to the number of billed visits, this still doesn't give the full picture of needed care by the client because self-pay or other funded visits are not reported.

<u>RECOMMENDATIONS:</u>

HCFA must ensure that a home health PPS system is based upon the following variables:

- functional status of the client (ability to complete activities of daily living)
- co-morbidity (presence of numerous health problems)
- client's age
- barriers to learning self care (sensory deficits, psychiatric illnesses, willingness to learn, language barriers, cultural or religious barriers, level of education, etc.)

- presence or absence of community support systems (meals on wheels, etc.)

HCFA must ensure that a home health PPS system is based upon the presence of an able and willing caregiver.

Limit the OASIS data elements to those necessary to implement the case-mix system for prospective payment.

The PPS system must be based upon OASIS data for Medicare-funded care and information on the total number of Medicare reimbursed and non-reimbursed visits needed to maintain the client in his/her home. HCFA needs to have a full understanding of the total cost of care needed to care for a client to make policy determinations about a long-term home care benefit or cost-adjustments for patients whose care makes them an outlier in the current system.

Reimbursement of the Cost of OASIS Implementation

The requirement for OASIS data collection and transmission has created an unfunded federal mandate for home health agencies. This mandate has that has manifested in the form of costs for computer hardware and software, staff training, revision of agency policies, new methods of tracking when assessments must be completed, new quality assurance audits of OASIS data, and other associated costs.

Two of the most frustrating events for agencies that have been trying to implement OASIS are the lack of final information in a timely manner and the many changes in the OASIS data set. Every change in the data set requires agency forms revisions and reprinting of forms. HCFA arrived at the conclusion that the OASIS data set would only add 3 pages to a start of care assessment form. Iowa agencies have experienced an increase in the assessment forms from 8 to 23 pages.

HCFA's cost estimates are erroneous. HCFA estimated printing at three (3) cents per page. This is exceptionally low. Most Iowa agencies are reporting minimum costs at ten (10) cents per page. HCFA did not calculate the every-second-calendar month update of the assessment resulting in a cost for non-billable visits.

There are hidden costs in the aggravation, frustration and number of mistakes caused by the lack of consistent, solid, and correct guidance. Agencies are willing to be compliant with HCFA's continued barrage of mandates, even at a time when our viability is at stake due to underfunding, but we need consistent and appropriate direction.

The Medicare program continues to shift the cost of care for the most elderly and frail beneficiaries to state and local governments. The needs have not changed; they still remain. So while Congress is congratulating itself on balancing a budget, it has come at the expense of the elderly and the providers who serve them. Less home care is being provided. More proud elderly are doing without care. More home care agencies and rural hospitals are closing. Access to care by rural elderly is just beginning to become problematic.

RECOMMENDATIONS:

HCFA should build in additional compensation for agencies, in terms of time, printing, and staff education, for each and every time it makes changes to the data sets after 2/24/99.

HCFA must fairly reimburse all start-up and ongoing costs of OASIS data collection and reporting on a pass-through basis.

Adjustment of IPS if PPS Implementation is Delayed

The very essence of home care is to prevent unnecessary, premature or inappropriate nursing home placements and hospitalizations. Home care agencies have responded to the challenge and increased capacity to care for the growing population of elderly in the nation. Just as we accomplished the goal set before us, we are being told that the increased capacity is due to fraud and abuse!

Iowa home care agencies provide cost-effective delivery of home care services, as evidenced by the 1996 data below:

National Ave. = 73.9 visits/client/year $86/visit charge $6355/client annual charges

Iowa Ave. = 49.4 visits/client/year $63/visit charge $3112/client annual charges

Make no mistake; the Balanced Budget Act (BBA) of 1997 made sweeping generalizations about home care providers. It continues to be far more detrimental to cost effective agencies. There is no fat to cut out.

Iowa agencies provided safe, effective services at half the cost of the national average. We didn't see HCFA trying to find out how Iowa home care agencies were able to provide cost-effective care to the most frail elderly in the nation. We didn't get the message that we were doing a good job of managing some of the most complex care for population who needed services the most. Instead, Iowa home care providers received the message that we were wasteful and fraudulent.

Payment for services should not be a mystery! No other industry is required to provide a service with no idea of how or what they will be paid. The IPS was implemented with full knowledge that a majority of agencies in the United States would in fact lose money. Part of the intent was a reduction in the number of home health agencies, which has occurred. Ten agencies have closed in Iowa to date as a result of BBA changes. This may not seem like a large number, unless you know that 90% of the Iowa home care providers have a fiscal year end coming up on 6/30/99. The full impact of IPS on Iowa providers can only be surveyed after FY 1999 cost reports are completed and filed.

The IPS cannot become a long-term payment strategy causing access barriers to home care for our nation's rural elderly. It needs adjustment beginning with the elimination of the automatic 15% reduction to become effective on 10/1/99.

RECOMMENDATIONS:

Elimination of the automatic 15% reduction in the IPS rate.

Adjustment of the per visit and the per beneficiary limits to fairly reimburse all start-up and ongoing costs of OASIS data collection and reporting on a pass-through basis.

Upward adjustment of the IPS if the PPS is delayed beyond 10/1/00.

HCFA's Responsibilities to Providers

There is wide spread distrust of HCFA by home care agencies due to the poor implementation and withdrawal of the surety bond and sequential billing (to end 7/1/99). OASIS data collection requirements is yet another example of failure in planning and implementing processes. HCFA has not clearly indicated their ability to make good use of data provided to them.

HCFA's conflicting statements about Y2K Compliance further undermine agencies' beliefs that HCFA will be able to receive and utilize OASIS data in a timely manner. Further, agencies are not even certain of HCFA's ability to continue to make timely payments for services rendered under a current system of payment, much less devise a better system. Finally, why should we believe that they will make good use of the fifteen-minute billing unit reporting requirement that is to become effective on 7/1/99?

HCFA has indicated their plan to provide agencies with *annual* reports and benchmarking data relative to OASIS data collection. This is unacceptable. In order to make quality performance improvements, agencies need timely data.

RECOMMENDATIONS:

HCFA must give a 90-day notice to re-implement OASIS data collection requirements, giving agencies adequate time to implement new systems.

HCFA must be required to fully utilize any data collected.

HCFA must be required to be Y2K complaint for data collection and service payment.

HCFA must be required to provide agencies with *quarterly* reports and benchmarking data, within 60 days of the end of each calendar quarter.

HCFA must establish a unified method of providing timely and consistent answers to providers' questions. These answers should be available on the OASIS web site, as well as through other mechanisms for agencies that do not have web access.

CONCLUSION:

Senators, thank you for your recognition of a huge national health care problem. Thank you for taking the time to be concerned about our elderly. You have the power to make HCFA comply with federal legislation and regulation. We are grateful for your efforts.

Iowa home health care providers, and a majority of the nation's providers, are very ethical. We are willing to comply with reasonable requests. We are willing to work with HCFA to find reasonable solutions to problems encountered. We are held accountable to the level of HCFA's highest standards. Mistakes on our part are not tolerated; they are construed as fraudulent. HCFA, on the other hand, is allowed serious lapses in good policy implementation. This affects our nation's elderly in terms of access to care.

Our elderly population needs to know that we are more interested in caring for them than we are in collecting data. The nation's home care providers need your help, but the nation's elderly depend upon you. I represent their silent voices today. Please listen; please help! Thank you!